MDR Tracking Number: M5-04-3572-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on June 22, 2004.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. The IRO agrees with the previous determination that the work hardening program and functional capacity evaluation rendered on 11/17/03 through 12/19/03 were not found to be medically necessary. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 21, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	Rationale
11/3/03 11/5/03 11/6/03 11/7/03 11/11/03 11/12/03 11/14/03	97545-WH-CA	$130.00 x 7 = $910.00	$0.00	A	According to the TWCC Rule 134.600 (h)(9), "work hardening and/or work condition programs that have not been approved for exemption by the commission…A comprehensive occupational rehabilitation program or a general occupational rehabilitation program constitutes work hardening or work conditioning, respectively, for the purposes of this section…" Therefore the requestor is entitled to reimbursement in the amount of $3,363.75.
11/3/03 11/6/03 11/7/03	97546-WH-CA	$325.00 X 3 = $975.00	$0.00	A	
11/5/03	97546-WH-CA	$308.75	$0.00	A	
11/11/03 11/12/03 11/14/03	97546-WH-CA	$390.00 X 3 = $1,170	$0.00	A	
TOTAL:		$3,363.75	$0.00		

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 11/3/03 through 11/14/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 8th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

NOTICE OF INDEPENDENT REVIEW DECISION

August 25, 2004

Rosalinda Lopez
Program Administrator
Medical Review Division
Texas Workers Compensation Commission
7551 Metro Center Drive, Suite 100, MS 48
Austin, TX 78744-1609

RE: Injured Worker:
MDR Tracking #: M5-04-3572-01
IRO Certificate #: IRO4326

The Texas Medical Foundation (TMF) has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to TMF for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

TMF has performed an independent review of the rendered care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by a matched peer with the treating health care professional. This case was reviewed by a health care professional licensed in chiropractic care. TMF's health care professional has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to TMF for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

This 43 year-old female suffered a twisting injury to her right foot, left knee, and lower back on __ when she fell into a 3-foot hole. Her diagnoses include degenerative disc disease and lumbar disc herniation. She has been treated with lumbar epidural steroid injections, physical therapy, foraminal nerve root blocks, and a work hardening program. She has opted not to have spinal surgery.

Requested Service(s)

Work hardening program and functional capacity evaluation for dates of service 11/17/03 through 12/19/03

Decision

It is determined that the work hardening program and functional capacity evaluation for dates of service 11/17/03 through 12/19/03 were not medically necessary to treat this patient’s medical condition.

Rationale/Basis for Decision

Medical record documentation indicates the work hardening program and associated functional capacity evaluation were not medical necessity since the patient obtained no relief from the treatments, promotion of recovery was not accomplished and there was no enhancement of the employee's ability to return to employment. Based on the patient's documented lack of response, the treatments were therefore not medically necessary.

Sincerely,